

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-021958

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5478

STATE FILE NUMBER

FILED JUN 3 1963

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO | | c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1 | | d. STREET ADDRESS (If outside, give location) 2122 MURPHY Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JACKIE LYNN MERRITT | | 4. DATE OF DEATH Month Day Year MAY 13, 1963 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 5/13/63 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no | | 10b. KIND OF BUSINESS OR INDUSTRY none | 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. 8 11 |
| 11a. FATHER'S NAME JOHNNY LEWIS MERRITT | | 11b. MOTHER'S MAIDEN NAME LOLA VIOLA DECKARD | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 17. INFORMANT Address: ST. LOUIS CITY HOSP. #1. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATURITY Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Epidermolysis Bullosa. DUE TO (b) 75%. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from 5/13/63 to 5/13/63 and last saw her alive on 5/13/63 Death occurred at 12:30 P m. on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Degree or title) M.D. 22b. ADDRESS 1515 LAFAYETTE AVE 22c. DATE SIGNED 5/13/63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 5-31-63 | 23c. NAME OF CEMETERY OR CREMATORY Anatomical Board | 23d. LOCATION (City, town, or county) St. Louis, Mo. |
| 24. FUNERAL DIRECTOR ADDRESS Rowland Mortuary Svc. 4104-06 Manchester | | 25. DATE RECD. BY LOCAL REG. MAY 23 1963 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

KATHOON
USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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ITEM NO.

DATE AMENDED

074080-127

1978

ALL CLEAR

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.